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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2014 027179

2014 MAY 14 PM 12:40

AFFIDAVIT OF TITLE OWNERSHIP
L. B. BROWN
RECORDER

Comes now Andrew C. Haskell, being duly sworn upon his oath, and states as follows:

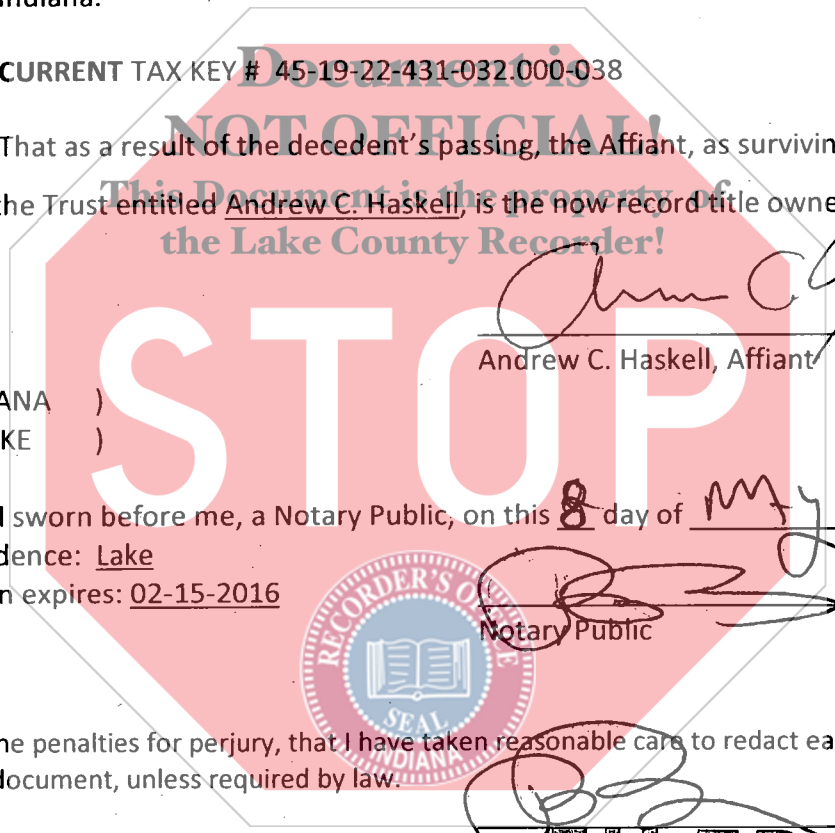
1. That the Affiant is the surviving child/son of the decedent, Angela G. Haskell aka Angeline Haskell who passed away on February 11, 2014. (See Certificate of Death, attached as Exhibit "A").

2. That at the time of the decedent's passing he was the owner with the Affiant of the following real estate:

Lot 81 in Indiana Heights Unit #4, in the Town of Lowell, as per plat thereof, recorded in Plat Book 36, page 65, in the Office of the Recorder of Lake County, Indiana.

CURRENT TAX KEY # 45-19-22-431-032.000-038

3. That as a result of the decedent's passing, the Affiant, as surviving sole beneficiary of the Trust entitled Andrew C. Haskell, is the now record title owner of the subject real estate.

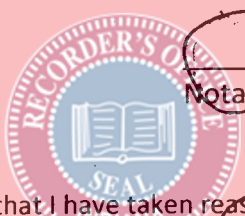


Andrew C. Haskell

Andrew C. Haskell, Affiant

STATE OF INDIANA)
COUNTY OF LAKE)

Subscribed and sworn before me, a Notary Public, on this 8 day of May, 2014.
County of Residence: Lake
My Commission expires: 02-15-2016



Paul A. Rossi

Notary Public

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security Number in this document, unless required by law.

Paul A. Rossi

FILED

MAY 14 2014

01904

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

#13
CS
G



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 09971

Local No 000528

EDR No 00000369599

State No 007088

1. Decedent's Legal Name (First, Middle, Last) ANGELA GERDA BETTI HASKELL				1a. Maiden Name: (If female) MUELLER		2. Sex FEMALE		3. Time Of Death 11:46 AM		4. Date Of Death (Month/Day/Year) 02/11/2014									
5. Social Security Number		6a. Age - Yrs 83		6b. Under 1 Year Months		6c. Under 1 Month Days		6d. Under 1 Day Hours		6e. Under 1 Hour Minutes									
7. Date of Birth (Month/Day/Year) 11/20/1930				8. Birthplace (City and State or Foreign Country) FUERTH, GM															
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)													
11. Facility Name (If Not Institution, Give Street and Number) 286 ARROWHEAD DRIVE										13. County Of Death LAKE									
12. City Or Town, State, And Zip Code LOWELL, IN, 46356						14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown													
15. Surviving Spouse's Name				15a. (If Wife) Give Maiden Last Name				16. Decedent's Usual Occupation HOMEMAKER		17. Kind Of Business/Industry DOMESTIC									
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town LOWELL						18c. Street And Number 286 ARROWHEAD DRIVE		18d. Apt. No.		18e. Zip Code 46356		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED				20. Decedent Of Hispanic Origin NOT HISPANIC				21. Decedent's Race GERMAN											
22. Father's Name (First, Middle, Last) CHRISTIAN ERWIN MUELLER				23. Mother's Name (First, Middle, Last) FRIEDA MUELLER				23a. Mother's Maiden Last Name LANG											
24. Informant's Name ANDREW HASKELL				24a. Relationship To Decedent SON				24b. Mailing Address (Street And Number, City, State, Zip Code) 286 ARROWHEAD DRIVE, LOWELL, IN 46356											
25. Place Of Disposition 25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):												25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) GEISEN CREMATION CENTRE		25c. Location - City, Town, And State CROWN POINT, IN		27a. Funeral Home License Number: FH83004277			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility SHEETS FUNERAL HOME AND CREMATION SERVICES, 604 E. COMMERCIAL AVENUE, LOWELL, IN 46356										27c. License Number (Of Licensee): FD09200061							
27b. Signature Of Indiana Funeral Service Licensee: MOLLY E. TUCKER, BY ELECTRONIC SIGNATURE										27d. License Number (Of Licensee): FD09200061		Approximate Interval: Onset To Death YEARS							
28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events - Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.												Approximate Interval: Onset To Death YEARS							
Immediate Cause (Final Disease Or Condition Resulting In Death) A. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (Or As A Consequence Of):												YEARS							
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last B. CORONARY HEART DISEASE Due to (Or As A Consequence Of):												YEARS							
C. ATRIAL FIBRILLATION												YEARS							
D. ESSENTIAL HYPERTENSION												YEARS							
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I												29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
HYPERLIPIDEMIA												29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
31. Did Tobacco Use Contribute To Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Unknown (Pregnant Within The Past Year)				33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined													
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) LAKE COUNTY HEALTH OFFICER				37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No.		38d. Zip Code											
39. Describe How Injury Occurred										40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		NOT VALID UNLESS							
41. Signature, Of Person Certifying Cause Of Death: JON DAVID MISCH, BY ELECTRONIC SIGNATURE										42. Certifier (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		44. License Number: 02000900A		45. Date Certified: 02/17/2014					
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: JON DAVID MISCH, 13963 MORSE STREET, CEDAR LAKE, IN 46303										47. *Alaska									
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE										49. For Registrar Only - Date Filed (Month/Day/Year): FEB 18 2014									

EXHIBIT
A

THE Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and need not be provided for release.

RAISED SEAL AFFIXED